FACT SHEET: **MEDICARE PROGRAM; MEDICARE PRESCRIPTION DRUG BENEFIT; INTERPRETATION (CMS-4068-F2)**

CMS published a final regulation entitled "Medicare Program: Medicare Prescription Drug Benefit" (CMS-4068) on January 28, 2005 (70 FR 4194). Subsequent to the publication of this regulation, CMS received inquiries requesting clarification of interpretations in the final rule. First, we received an inquiry concerning whether a joint enterprise could be considered an "entity" under section 1860D-12(a)(1) of the Social Security Act (the Act), for purposes of offering a PDP. The participating health plans would contract with each other to create a single "joint enterprise." Second, we received inquiries from parties about our discussion of the actuarial equivalence standard as to whether an employee health plan sponsor could apply the aggregate net value test under §423.884(d)(5)(iv) of the final rule. In addition, we are making another clarification based on comments received in the August 3, 2004 proposed rule (69 FR 46684-5) on how the late enrollment penalty would be coordinated with the late enrollment penalty for Part B. Finally, we are providing clarifying language related to transitioning Part D enrollees from their prior drug coverage to their new Part D plan coverage.

This final regulation clarifies these four issues. Because these are clarifying interpretations to the preamble of the final regulation, we are required to publish this final rule prior to the effective date of the Medicare Prescription Drug Benefit Final Rule, which is March 22, 2005. These interpretations would be deemed to be included in that final rule.

The statute generally requires that the "entity" be licensed by the State as a risk bearing entity where it offers benefits. The organizations seeking jointly to offer a PDP propose to meet this requirement through the State license that each participating plan holds in the State in which it does business. Each plan would be at risk for, and fully responsible for, each PDP enrollee in its State, or portion of a State in which it is licensed and operating. Together, the entire region would be covered by an insurer licensed by the State to bear risk where the enrollee lives. In considering this proposal, we have determined that such a joint enterprise could be treated as a single "entity" for purposes of offering a PDP, as long as the enterprise as a whole meets all applicable Medicare requirements, and there is no substantive difference between this arrangement and a traditional entity from a Medicare enrollee's perspective.

Section 423.885(d)(5)(iv) of the final rule provides that for a sponsor maintaining employment-based retiree health coverage with two or more benefit options, a sponsor must attest that all benefit options for which the sponsor claims the retiree subsidy separately satisfy the gross value test, and either separately or in the aggregate satisfy the net value test. This establishes the principle that the sponsor can identify the benefit options for which it is potentially seeking a subsidy. After considering the above inquiry, we believe that §423.885(d)(5)(iv) can be read to permit a sponsor to claim the retiree subsidy for (1) all benefit options that separately meet the gross value test and the net value test, (2) all benefit options that separately meet the gross value test and in the

aggregate meet the net value test, and (3) a subset of the benefit options that separately meet the gross value test and in the aggregate meet the net value test.

Additionally, we clarify that the example for the calculation of the late enrollment penalty given in the proposed rule, published on August 3, 2004, was incorrect because it did not account for the fact that the base beneficiary premium increases on an annual basis. We stated in the example in the proposed rule at 69 FR 46684, that if the penalty amount is $.36 per month in 2004, and beneficiary is subject to 12 months of penalty, the beneficiary will pay an additional $.36 * 12 or $4.32 per month as long as they are enrolled in Part D. We are clarifying that the example provided in the proposed rule conflicted with regulatory language and could not be correct because it did not account for the fact that the base beneficiary premium, upon which the penalty is based, changes on an annual basis. We provide an interpretation that as the base beneficiary premium increases, the late enrollment penalty must also increase, and is in keeping with how the Part B penalty is calculated.

In the preamble to the final Medicare Prescription Drug Benefit regulation (FR 70 4194), published on January 28, 2005, we responded to comments on the need expressed by a number of commenters supporting a transition period for beneficiaries, particularly full-benefit dual eligibles who are transitioning to the Medicare Part D benefit from other drug coverage. We responded by agreeing with the commenters that Part D plans should have processes in place to transition current enrollees from their old coverage to their new Part D plan coverage, particularly in cases in which the beneficiary is taking Part D drugs that are not covered on the plan's formulary at time of enrollment. We further responded that "we envision that the need for such a transition period will be limited for several reasons."

In this final rule, we clarify what we meant by this latter statement. We did not intend to signal with this statement that there should be a very limited application of, need for or duration of transition plans. What we intended to say is that there are other beneficiary protections in the formulary review and exceptions and appeals processes that would meet some of the same needs. Instead, we know that there are a variety of circumstances in which a beneficiary will need to be appropriately transitioned from their currently prescribed drugs to alternative drugs covered under the Part D plan's formulary. It is for these special circumstances that we require Part D plans to have an established transition process.

To further clarify this transition issue, we provide a brief discussion of the importance we place on protecting beneficiaries as they transition from prior drug coverage to their new Part D plan coverage and an overview of our expectations for Part D plans as they develop their transitions processes.